

TRANSPLANT REFERRAL FORM (Page 1 of 2)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address		City	State		ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment					
Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed		
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergies (please list) <input type="checkbox"/> Other (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted	
ICD-10 Codes <input type="checkbox"/> Kidney (Z94.0) <input type="checkbox"/> Kidney/Pancreas (Z94.0/Z94.83) <input type="checkbox"/> Heart (Z94.1) Lung (Z94.2) <input type="checkbox"/> Heart/Lung (Z94.3) <input type="checkbox"/> Liver (Z94.4) <input type="checkbox"/> Bone Marrow (Z94.81) <input type="checkbox"/> Intestines (Z94.82) <input type="checkbox"/> Pancreas (Z94.83) <input type="checkbox"/> Other Code _____ Description _____					

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
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IMMUNOSUPPRESSANTS

<input type="checkbox"/> Azathioprine	<input type="checkbox"/> 50 mg tablet <input type="checkbox"/> 50 mg/mL cmpd susp			
<input type="checkbox"/> Cyclosporine modified	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg capsule	<input type="checkbox"/> 100 mg/mL solution (unbreakable bottle of 50 mL)		
<input type="checkbox"/> Everolimus	<input type="checkbox"/> 0.25 mg tablet <input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 0.75 mg tablet	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 5 mg tablet		
<input type="checkbox"/> Mycophenolate	<input type="checkbox"/> 250 mg capsule <input type="checkbox"/> 500 mg tablet	<input type="checkbox"/> 200 mg/mL suspension (unbreakable bottle of 160ml)		
<input type="checkbox"/> Mycophenolic acid	<input type="checkbox"/> 180 mg tablet <input type="checkbox"/> 360 mg tablet			
<input type="checkbox"/> Prednisone	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 5 mg tablet	<input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 5mg/mL solution		
<input type="checkbox"/> Prednisolone	<input type="checkbox"/> 5 mg/mL solution <input type="checkbox"/> 5 mg/5 mL solution	<input type="checkbox"/> 15 mg/5 mL solution		
<input type="checkbox"/> Sirolimus	<input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet	<input type="checkbox"/> 1 mg/mL solution (unbreakable bottle of 60 mL)		
<input type="checkbox"/> Envarsus XR (Tacrolimus ER)	<input type="checkbox"/> 0.75 mg tablet <input type="checkbox"/> 1 mg tablet	<input type="checkbox"/> 4 mg tablet		
<input type="checkbox"/> Tacrolimus IR	<input type="checkbox"/> 0.5 mg capsule <input type="checkbox"/> 1 mg capsule	<input type="checkbox"/> 5 mg capsule <input type="checkbox"/> 0.5 mg/mL cmpd susp		

Total RXs _____

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must handwrite)	

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER)					
Patient Last Name		Patient First Name		DOB	Date of Issue
Patient Address			City	State	ZIP
Prescriber Name			NPI #	DEA #	
Prescriber Address			City	State	ZIP

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
ANTIFUNGALS				
<input type="checkbox"/> Clotrimazole	<input type="checkbox"/> 10 mg troche			
<input type="checkbox"/> Fluconazole	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 150 mg tablet <input type="checkbox"/> 200 mg tablet	<input type="checkbox"/> 10 mg/mL suspension (unbreakable bottle of 35 mL)		
<input type="checkbox"/> Nystatin	<input type="checkbox"/> 100,000 u/mL suspension			
ANTIVIRALS				
<input type="checkbox"/> Valganciclovir	<input type="checkbox"/> 450 mg tablet	<input type="checkbox"/> 50 mg/mL solution (unbreakable bottle of 88 mL)		
PCP PROPHYLAXIS/ANTIBIOTICS				
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> 250 mg tablet <input type="checkbox"/> 500 mg tablet	<input type="checkbox"/> Cipro 250 mg/5 mL suspension (unbreakable bottle of 100 mL)		
<input type="checkbox"/> Dapsone	<input type="checkbox"/> 25 mg tablet <input type="checkbox"/> 100 mg tablet	<input type="checkbox"/> 2 mg/LI compd suspension		
<input type="checkbox"/> SMZ/trimethoprim	<input type="checkbox"/> 400 mg/80 mg SS <input type="checkbox"/> 800 mg/160 mg DS	<input type="checkbox"/> 200 mg/40 mg/5 mL susp		
GASTROINTESTINALS				
<input type="checkbox"/> Famotidine	<input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 40 mg tablet	<input type="checkbox"/> 40 mg/5 mL suspension (unbreakable bottle of 50ml)		
<input type="checkbox"/> Omeprazole	<input type="checkbox"/> 20 mg capsule <input type="checkbox"/> 40 mg capsule	<input type="checkbox"/> 2 mg/mL compd suspension		
<input type="checkbox"/> Pantoprazole	<input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 40 mg tablet	<input type="checkbox"/> 40 mg packet		
MISCELLANEOUS				
<input type="checkbox"/> Amlodipine	<input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 5 mg tablet	<input type="checkbox"/> 10 mg tablet		
<input type="checkbox"/> Aspirin	<input type="checkbox"/> 81 mg chewable tablet <input type="checkbox"/> 81 mg DR tablet	<input type="checkbox"/> 325 mg tablet <input type="checkbox"/> 325 mg DR tablet		
<input type="checkbox"/> Furosemide	<input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 40 mg tablet <input type="checkbox"/> 80 mg tablet	<input type="checkbox"/> 10 mg/mL suspension (unbreakable bottle of 60 mL)		
<input type="checkbox"/> Katerzia (amlodipine)	<input type="checkbox"/> 1 mg/mL			
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				

Total RXs _____

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must handwrite)	

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